

THE MEDICAL AND SURGICAL REPORTER.

No. 736.]

PHILADELPHIA, APRIL 8, 1871.

[Vol. XXIV.—No. 14]

ORIGINAL DEPARTMENT.

COMMUNICATIONS.

CASE OF HEPATITIS, WITH ABSCESS.

By J. R. TAYLOR, M. D.,

Of Kosse, Texas.

Mr. T. S., æt. 34; sanguine temperament; regular habits, and a farmer, was attacked December 26th, 1870, with inflammation of the liver. A physician was called, but I know not what he prescribed, except a large blister over right lung. I saw him on 31st, and found him suffering with severe pain in the region of the liver and right shoulder; considerable fever, and tongue thickly coated; pulse, 100; respiration, 35. A small cathartic pill was ordered every two hours, until the bowels were well evacuated—quinia during interim, while morphia and topical measures were used to allay the pain.

January 1.—Patient better. Bowels moved well to-day, and fever abating. Still considerable pain when not under morphia. Pulse, 85; respiration, 25. Quinia continued.

January 2.—Patient much better. Tongue cleaning; fever absent; pain rapidly diminishing; pulse, 75; respiration, 20. Quinia and muriatic acid thrice per day.

Patient rapidly convalesced. Went about his business till February 9, 1871, when, becoming exhausted from over-fatigue, and suddenly cooling himself, a chill ensued, followed by high fever, and a return of former pain. This occurred late in the evening, and I saw him early that night. Pulse over 100; respiration hurried; cheeks flushed; all indicating great internal disturbance. I immediately administered a large dose of quinia and morphia, and in a little while he was quiet. A poultice, saturated with turpentine, was placed over the liver.

February 10.—Is better. Bowels moved. Quinia continued, with mild restoratives.

His improvement was again rapid, and on 12th was apparently convalescent—was sitting up, etc. But on this day a severe norther came up, with sleet and rain, and, living in an open house, he relapsed early in the night, and I was sent for in haste. I found him completely prostrated. Brandy and ammonia were freely administered, and reaction occurred in an hour. Both lungs were considerably congested. Liver much above normal size, but no abscess discoverable. My suspicions had been aroused some time before this, and I suspected the rupture of an abscess into the peritoneal cavity to be the cause of the seemingly fatal collapse. Continuing the stimulants during the night, the condition of my patient next day caused me to change my base, and attribute it simply to the cold he had taken.

February 13.—Ordered calomel till the bowels moved, also quinia and ipecac. Pulse had lost somewhat of its wiry touch—was 95; respiration, 30. Liver still greatly enlarged, and very painful on pressure; sinapisms, turpentine stupes and dry cups afford relief. Bromide of potash now causes him to rest well. Although the great disproportion between the pulse and respiration has, all the time, indicated serious lung disturbance, yet I have never been able to detect any thing more than engorgement of lower lobe of right lung, which has never passed on to second stage or rusty sputa. The continual cough I attributed to the nervous connection between the lung and liver. Under the most efficient tonics and diet my patient's improvement was slow, till March 11th, when he rode out some half mile. Sudden fits of coughing came on; he returned home, and early in the night he

felt something burst, followed by copious expectoration of a yellowish and bitter substance. An abscess had broken into the right bronchial tube. I would here state that February 13th he had some fifteen or twenty dejections in as many hours, of pretty much the same substance, and I believed then an abscess had opened into colon or duodenum. His improvement since last rupture has been more rapid, the expectoration has nearly ceased, and he is now, March 17th, at work on his farm. No dysentery attended any stage of the disease. I am satisfied the origin of his attack was malaria. His tongue indicated it.

URETHRAL FISTULA.

By WILLIAM FAULKNER, M. D.,
Of Waterford, Pa.

In the latter part of December, 1869, I was consulted by G. Y., æt. 36. He said he had been discharged from the army seven years before for stone in the bladder; that his sufferings had become so great that he could not endure it any longer. He was a tall, large-boned man; looked thin, and wore an expression of anxiety and suffering; had been raised in this county (a free-stone region), and had always enjoyed good health up to the time of entering the army.

Upon examination I found an unyielding stricture just below the scrotum, complicated with urethral fistule of something over two years' standing, and about half of the urine was discharging through this opening. The external orifice was the smaller of the two, and not having free exit, the urine had dissected up the parts in every direction, inflaming the tissues, forming false channels and cavities, which had become coated over with an adventitious membrane, discharging large quantities of a thin, acrid matter, that inflamed the parts wherever it touched them. Professor GROSS has said: "A person affected with urethral fistula is to be regarded as an object of the deepest sympathy and commiseration," but never until I had examined this man's case had I fully appreciated the truth and force of the professor's remarks.

This man was truly an object of sympathy, pity and solicitude, presenting a complication of interesting and grave difficulties. After a few days of preparatory treatment, with a view of bettering his condition somewhat, on the 8th of January, 1870, I opened freely

into this mass of disease, cutting down to the point of a catheter resting upon the stricture.

The internal fistulous orifice was found a few lines below the stricture. I then passed a small grooved director into the orifice, and up through the stricture, and divided it. The catheter was then carried into the bladder, when all the false channels connected with the fistula were opened into one common cavity, as far as practicable. The wound was filled with lint, wet in a weak solution of carbolic acid. A hypodermic injection of morphia was given, and the patient put to bed, with the request to retain the catheter during the night if he could. But upon visiting him the next morning I learned that he had removed the instrument, the bladder having proved too irritable to tolerate its presence. I then made it a practice to introduce the instrument every day, and have it retained from one to three hours. He soon learned to use it himself, after which he used it every time he urinated. From this date he experienced very great relief from the operation, and as soon as I deemed it prudent I sounded him, and readily detected a calculus (as I believed) of full average size. The wound was kept open and allowed to fill up from the bottom, but it granulated slowly, and it was not before the middle of February that I thought it prudent to cut him.

There was some urine passing through the fistulous opening at this time, but I thought it would close up, while the water would be discharging by way of the perineal incision. He took a laxative on the evening of the 14th, and at 10½ o'clock, A. M., on the 15th, he was given a hypodermic injection of morphine; placed upon the table; hands and feet secured; staff introduced; chloroform given and the lateral operation performed in the usual manner in the presence of Drs. BARTON, W. V. BLAKESLEE, J. H. GRAY, and my brother, M. L. FAULKNER, to whom I confided the staff. There was very little hemorrhage, but great depth of perineum. The calculus removed was an oxalate of lime formation, surface tuberculated, and measuring over four inches in its largest circumference. His recovery was not rapid; the wound granulating slowly as did the other, but it was uninterrupted by any unpleasant symptoms, and it was in the latter part of April that he reported to me, looking like a new man, and said that he was perfectly sound, and remains so up to this date.

MEDICAL SOCIETIES.

CINCINNATI ACADEMY OF MEDICINE.

[REPORTED BY J. W. HADLOCK, M. D.]

February 6th, 1871.

Renal Tumor, with Death of Patient.

Dr. GOOD exhibited a specimen taken from a boy eight years old of the bladder, kidneys and a pathological sac apparently connected with either the kidneys, bladder, or by either the ureter or an abnormal tube. The speaker had not made a critical examination of the specimen, preferring to refer it to the proper section.

The boy died at the age of eight years and five months, from simple exhaustion. He first came under Dr. Good's observation in the spring of 1865, when a little over three years old, presenting, as his mother stated, "something about the abdomen."

The peculiarity consisted of a tumor which occasionally presented in the left lumbar region; rapidly increased in size and always in a short time; suddenly collapsed with the escape of a large amount of urine per urethra. With the collapse of the tumor the distressful symptoms subsided in every instance which attended its formation. No opportunity was afforded of seeing the tumor until the spring of 1868, when he was confined to his bed for ten days. Drs. WOOD, STEPHENSON and MILLER all agreed that it was an accumulation of urine, but had not ventured any theory as to its connection with the bladder or kidney. On one occasion as much as nine pints of urine were discharged on the collapse of the tumor, passing in from thirty minutes to an hour.

Notwithstanding the pain and fever attendant upon each collection of the fluid, the boy continued to grow and develop with the integrity of every function, even those of the brain. On the 26th of October, last year, another tumor formed, pointing like the rest toward the left groin. It continued to increase in size, never evincing any symptoms indicating its termination as on previous occasions. Small quantities of highly colored urine were voided normally.

At the end of three weeks some three pints escaped. At this time the tumor was very large, occupying the whole pelvic cavity, and leaving in the abdominal but a small tympanitic surface on the extreme right. There was now great pain and tenderness, vomiting, emaciation, and finally death, as stated, by exhaustion.

On autopsy, the entire abdomen was filled with a continuous tumor except at the right side, where was found the displaced stomach and intestines. Seven pints of urine were removed after extraction of the tumor. The peritoneum was found so firmly

adherent to the tumor as to require considerable force to detach it.

The speaker preferred, as intimated, to advance no theory as to the character of the abdominal sac. As remarkable, is noticed the suddenness of its collapse, and the suddenness of the relief to all the unpleasant symptoms. The specimen was then referred to the section on pathology and morbid anatomy. The following is the report of the section, with some remarks by Dr. W. W. DAWSON.

The section on pathology and morbid anatomy begs to present to the Academy the following report in regard to the kidneys referred to it on last Monday evening:

Upon the anterior surface of the left kidney was a large cyst, which had contained nearly a gallon of fluid, but which at the time of the examination was very much collapsed from immersions in alcohol. The walls of this cyst were mainly composed of the capsule of the kidney; remarkably dilated and thickened posteriorly was the anterior surface of the kidney itself, between which and the capsule the fluid had accumulated. The length of the left kidney was 7 inches, its breadth $3\frac{1}{2}$, and its thickness 1 inch. The surfaces and borders were extremely irregular. The pelvis was dilated and occupied a considerable portion of the posterior surface of the organ. Its dimensions were 3 inches by $1\frac{1}{2}$. At the bottom of the pelvis were seven openings leading to cavities in the substance of the kidneys. These cavities varied in depth from $\frac{1}{2}$ to $\frac{3}{4}$ of an inch. Between the upper one and the cyst there existed a communication by an opening $\frac{1}{2}$ of an inch in diameter in the proper substance of the kidney. The ureter emerged from the pelvis at its lower and internal part by an opening slightly oblique, but of normal size. Its calibre between the bladder was quite normal. The renal substance was atrophied.

The right kidney was diminished in size; length, $3\frac{1}{2}$ inches; breadth, 3 inches at one portion, $1\frac{1}{2}$ at another; thickness, $1\frac{1}{2}$ inches. The pelvis was dilated, and contained about two ounces of turbid fluid, of which a considerable portion was alcohol, which penetrated through the walls. It was 3 inches in length by $2\frac{1}{2}$ in depth. In it there were also seven openings, varying from $\frac{1}{2}$ to $\frac{3}{4}$ of an inch in diameter, and communicating with cavities about $\frac{1}{2}$ an inch in depth. Upon tracing the ureter upward it was found to join the kidney at the inner portion of its inferior extremity. It there extended in the wall of the pelvis, between fibrous and mucous cuts, an inch and a half before opening into its cavity. Its orifice was valvular, smaller than normal, and was located about the middle of the internal border. It required some pressure to force the fluid contained in the pelvis through the ureter. The ureter was neither dilated nor contracted. The

substance of the kidney at the upper part was $\frac{1}{2}$ of an inch in thickness.

The consistence and color of both kidneys were altered, but whether from immersion in alcohol, or from some morbid process, was not ascertained.

The bladder was very small, 3 inches by 2. Before being opened its thickness was $\frac{1}{2}$ of an inch. Thickness of fundus $\frac{1}{2}$ of an inch. Mucous membrane healthy.

The fluid from pelvis of right kidney, when subject to microscopical examination, was found to contain columnar and pavement epithelium, having a granular appearance; also granular matter and a few granule corpuscles. The solid residue obtained by evaporating the fluid to dryness, re-dissolving in alcohol, and again evaporating, afforded no indication of urea on the addition of nitric acid.

In some respects the case is quite unique. The large cyst developed upon the left kidney was not, as is usual in cases of nephrosis, formed by the dilated pelvis, the flattened remains of the atrophied kidney and the capsule, but by the anterior portion of the capsule and the kidney, between which the urine, after having broken through the renal substance, had gradually accumulated, detaching the capsule from the kidney and dilating it into the large sac found after death. To this cause is in all probability due the small amount of atrophy of the kidney observed, for with such a tumor formed, as in most cases of hydrocephalus, a much greater amount of atrophy would have been found.

The right kidney exhibited in a very marked manner the most common cause of this condition, namely, congenital malposition of the upper portion of the ureter. As stated, this tube ran for an inch and a half in the walls of the pelvis, and then opened into it by a valvular slit. This rendered it liable to be closed by the slightest accumulation of urine in the pelvis. In the left kidney this condition was observed but to a limited extent. The ureter, instead of joining the pelvis by a gradual funnel-shaped expansion in the middle of the hilus, entered its lower and internal portion by an oblique opening of which the calibre was no greater than that of the ureter below. It seems very probable that at birth the same condition existed in the left as was subsequently found in the right (perhaps to a limited extent), and that afterward, as the pelvis became dilated, it assumed an altered relation to the ureter.

It will be readily understood that patients afflicted with this disease, even if it be limited to one kidney, hold their life by a most uncertain tenure; yet it is very extraordinary that in some cases in which both kidneys have been completely atrophied so that no trace of their substance could be detected after death, the patients have lived for some time. Two such cases are referred to in Roberts's treatise; one

of Dr. STRANGE, published in Beale's Archives, the other of Dr. FABER.

The size to which these tumors attain is sometimes very great. Roberts alludes to a case published in the *Phil. Trans.* in 1747, in which the tumor contained thirty gallons of fluid. The diagnosis of these immense collections is frequently very obscure. Dr. BRIGHT, in his treatise on abdominal tumors, states that he has known tumors of the kidney mistaken for those of the liver, spleen, uterus and ovaries. The latter would probably be the most common source of error. SKODA had a girl tapped, supposing that she had ovarian dropsy; subsequently she was several times tapped with temporary benefit. When she died it was found that there was hydronephrosis of one kidney. This case is also referred to by Roberts. A case worthy of note in connection with tapping was published by Mr. THOMPSON, of Nottingham, in the *Path. Soc. News*.

The diagnosis in this case was almost certain, as the patient at one time had passed per urethram a large quantity of fluid, the tumor at once disappearing. It, however, returned, and was tapped, January, 1852, the trochar being introduced between the eleventh and twelfth ribs, and eight quarts of fluid withdrawn. The sac again filled, and was a second time tapped, December, 1852. The patient remained well until March, 1860.

The contents of these cysts vary considerably. Generally they contain sero-albuminous fluid, having in solution some of the constituents of the urine. In the specimen referred to the section, none of these organic materials were found, and probably none existed, as urea would have been present in such case. Sometimes the material is colloid. NIEMEYER remarks, in his Practice, that the fluid accumulating in the pelvis soon presses so much upon the papillae that no more urine is secreted, and hence the small amount of urea, etc., usually found. The increase in size of the sac afterward he refers to the secretion of the mucous membrane lining it.

Among other cases alluded to by Roberts, is one of Dr. HILLIER's, originally reported in volume 48 of *Medical and Chirurgical Transactions*, as a successful case of surgical management. Boy, then 3 years and 4 months old. Much irritation and depression followed the several tapplings; after one of the operations a quantity of fluid was passed from the bladder, similar to that from the cyst, and quite unlike what was usually passed from the urethra—a temporary communication thus obviously being established between the cyst and the bladder. At the first report of the case there had been no operation for several months, and the patient had regained his strength, but the cyst remained, and his urine was often purulent and fetid. That history terminated in December, 1865.

Between that time and July, 1863, when the his-

tory of the case is resumed (in vol. 52, *Medical and Surgical Transactions*), he was tapped once and a quantity of urine-like fluid was drawn off. He died August 5th, after more or less of uræmia. On post-mortem examination the cyst was found to fill the greater part of the abdominal cavity. Its posterior portion was found to occupy the situation of the right kidney, and the supra-renal body of normal size and body was attached to it. In the right loin the cyst presented a constriction, behind which a portion of the cyst presented somewhat a greatly enlarged kidney; the color, however, was pale and bladder-like. One very small part of the cyst-wall, near what would be the hilus of this reniform part of the cyst, showed a very pale kidney color; the main body of the cyst, in front of this, was globular or ovoid. The ureter was found proceeding from the lower part of the cyst, attached for about an inch to its wall. This ureter, examined from its vesical end, was found to enter by a much smaller orifice than usual; the ureter was smaller than normal. The cyst measured 27 inches in circumference over the long diameter, and 24 over the short one. It was 9 inches long, 8 wide, and 6½ deep, and contained 83 ounces clear fluid, having lemon color and urinous smell; sp. gr. 1002, slightly acid, a trace of albumen. The obstruction was found to be due to an abnormally small ureter, a congenital stricture, through which fluid did not usually pass; although it might do so under extreme pressure from dilatation. The dilatation of the left pelvis was due to calculous matter, which occasionally clogged the ureter.

Dr. DAWSON.—One of the features of the case of Dr. Good, the history of which he gave at the last meeting, and upon the pathological specimen of which the section on pathology have this evening reported, was a periodical subsidence of the abdominal swelling after a sudden gush of fluid from the urethra. This feature of the case led Dr. Good to a positive diagnosis—the only one which he could make—a renal cyst.

The section on pathology have referred to the case of hydronephrosis reported by Dr. THOMAS HILLERS in the "*Medico-Chirurgical Transactions*" Vols. 48 and 52. The patient was a boy three years and four months old when first seen by Dr. Hillers. He lived until August, 1868, being something over eight years of age at his death. He was tapped frequently near the median line and with temporary relief. When we reflect that this tumor was diagnosed as renal we can but wonder that the tapping was done in front, and our wonder is still greater at finding that, although the fluid obtained was dilute urine, that the boy survived the first operation. The point to which I wish to call attention is the resemblance between this case and the one reported by Dr. Good, in the occasional subsidence

of the tumor by a sudden gush of fluid through the urethra. The mother stated that on several occasions he had passed large quantities of fluid by the urethra, and accompanying these discharges there was a marked subsidence of the swelling. The post-mortem showed that the ureter did not enter the cyst direct; that it passed for some distance along its walls; that the moderate distension of the cyst prevented the escape of the fluid. When, however, the distension became too great, the fluid would press its way through the ureter and escape by the bladder.

The diagnosis of abdominal tumors is presented to the mind of the physician by such cases; and when we reflect that so distinguished a man as SPENCER WELLS has mistaken a renal cyst for an ovarian dropsy, the definition of these enlargements becomes a matter of the most vital interest. Dr. HENRY COOPER ROSE, in the "*Medico-Chirurgical Transactions*," vol. LII, reports a case of cystic degeneration of the kidney simulating in a remarkable degree ovarian disease. The case, I think, will show very forcibly the uncertainty of a positive diagnosis. The patient was a young lady, 18 years of age when first seen, in 1856, by Dr. Rose. Two years previously she had noticed blood in her urine, and I may say that in the subsequent eleven years of her life, not only blood, but pus and albumen were frequently detected. Dr. Rose, on his first examination, found a tumor occupying the position of the left ovary, about the size of an orange. The uterus was moveable and normal in size. In 1861, after the tumor had enlarged so as to fill the whole space from the pubes to the diaphragm, Spencer Wells diagnosed it as either ovarian dropsy or pelvic abscess. In 1865 the tumor was tapped, and yielded a sanguinous, clotty fluid, without a trace of the elements of urine in it. In 1866, one year before her death, the uterus could not be felt by a vaginal examination. The points to which I wish particularly to direct the attention of the Academy are, the position of the tumor when first examined, and the conduct of the uterus. The position of the tumor when first discovered was not in the loins, between the ilium and ribs, the locality where renal cysts generally manifest themselves, but in the region of the left ovary; and from this nucleus the enlargement proceeded. This is, as is well known, the history of the great majority of ovarian tumors. The conduct of the uterus was such as is frequently found in ovarian dropsy. In most of these cases the uterus is at first in its normal position, but by a close attachment to the ovary, the ascending tumor lifts it so high in the vagina that it can no longer be reached by the finger. In renal enlargements the uterus is usually undisturbed, at least until the tumor becomes so great as to encroach upon its fundus and press it deeper into the vagina. By some acci-

dental adhesion in Dr. Rose's case, however, the uterus became attached to the tumor, and as the latter increased in size the former was dragged upward. These two diagnostic elements, probably never before associated with renal enlargement, and so essentially characteristic of ovarian dropsy, presented to the surgeons almost positive evidence that the disease was of the latter character. The sanguineous, clotty fluid, without an element of urine in it, which was drawn from the tumor, was also well calculated to exclude the kidney.

The diagnosis between renal and ovarian cysts may in most cases be made with tolerable certainty. 1st. The situation of the kidneys behind the peritoneum necessarily places the bowels in front of them, when enlarged or dropsical. On the right side the colon would be pushed forward and toward the median line. On the left the descending colon would form a longitudinal ridge. This was the portion of the colon in the unfortunate case of Spencer Wells. Down the front of the union, about an inch to the left of the umbilicus, was a cord-like ridge, which was taken by some who examined it for intestines, though it felt to Mr. Wells, as he says, very like a large, long and thick Fallopian tube. When he made his abdominal section he found that this cord-like ridge was the descending colon. He pressed it out of the way, tapped the cyst, but found it so liberally attached at its base that he did not attempt to remove it. The *post-mortem* showed that it was a renal instead of an ovarian cyst. Something may be done in the way of defining a ridge in front of an abdominal tumor. The patient may be conscious of gurgling flatus along it if it be intestine. Mr. Wells speaks of the bowels, when rolled under the finger, contracting with a firm cord-like movable roll. Again, the cord, if it be the colon, may be distended by insufflation by a tube through the rectum. Ovarian tumors are almost always in front of the intestines. 2d. The situation of the tumor on its first appearance, the ovarian in the iliac region, the renal in the loins. This point I discussed when speaking of Dr. Rose's case. 3d. A floating kidney may be diagnosed from a small ovary with a long pedicle by its shape. The former would be of its characteristic form notched at the pelvis, whilst the latter would be regular in outline and globular or ovoidal. 4th. Renal cysts are always associated with disturbance of the urine, blood, pus or albumen, or all of them may be found in the secretion. Ovarian disease is just as constantly associated with disorder of menstruation.

NEW YORK PATHOLOGICAL SOCIETY.

March 22d, 1871.

President Dr. A. S. LOOMIS in the Chair.

Dr. STEPHEN ROGERS reported, in behalf of the Microscopical Committee, two specimens of

Subcutaneous Fibroma.

The specimen removed by Dr. POST from the right scrotum proved to be a subcutaneous fibroma.

Polypus Uteri.

The uterine growth presented by Dr. NOLAN gave the histological evidences of polypus uteri.

Fracture of Skull Comminuted.

Dr. ——— presented some fragments of a skull removed from a patient, also the patient from whom they were removed. He received a kick from a horse on the 17th of September, 1868, inflicting a wound 2½ inches long. An incision was made at right angles to the wound, and eight or ten small fragments and spiculæ taken out. For three days patient was comatose, but gradually rallied. The case was interesting, showing the amount of injury that the brain can receive with impunity.

Atheroma of Aorta.

Dr. FINNELL read the history of a case of rheumatism in which there was a murmur and very much precordial pain. This was two years ago. For the relief of his symptoms became a gin drinker, and recently during an attack of delirium tremens died.

No lesion was discovered to account for either symptoms or murmur, beyond a very atheromatous aorta.

The President said that in his opinion the cause of the murmur was due to the toughened aorta, and asked if an impulse was detected to the right of the sternum.

Dr. Finnell said the impulse was very marked.

Necrosis of Femur.

Dr. SAYRE presented a specimen, and also patient from whom it was removed.

The boy in falling down caught on the rung of a ladder with the condyles of the femur, the leg being flexed. Dr. S. is of opinion that a periostitis set up, followed by necrosis. The point of interest in the case was the fact that it was suspected to involve the joint, and on this account a consultation had been called, amputation being suggested.

Dr. Sayre called to mind three similar cases, where, from an injury affecting the lower portion of femur or condyles, necrosis had resulted.

Periostitis Following Fracture of Tibia.

Dr. Sayre presented, also, an amputated leg and thigh with history.

Patient, a boy, got his tibia fractured at the epiphyses, but was allowed to walk around. Poultices were applied and extended till the whole limb was covered. When Dr. S. saw the case patient was apparently in extremis. The leg and the thigh gave evidences of fluctuation, and was amputated about three inches above the knee joint. The whole of the periosteum or tibia was exfoliated, but the joint itself was healthy. Very shortly after the operation his condition was found to be improved, and he is now doing well.

Fibromia of High Labium.

Dr. POST presented a fibroid tumor from the right labium. Had been of two years standing. The interest of the case centered in the fact that a similar tumor was presented at the last meeting of the society of about the same size, and removed from the right scrotum. Dr. P. had never met with either before.

CHEMUNG COUNTY, NEW YORK, MEDICAL SOCIETY.

A Quarterly Meeting of the Chemung County Medical Society was held on Tuesday, March 14th, 1871, Dr. GEO. DEAN, President, in the chair.

Dr. ABBOTT read the particulars of a case of retention of urine, in prostatic disease, in a man set. sixty years, consequent upon indulgence in liquor. Relief was obtained by the use of a common catheter, and ten months elapsed before a second attack, produced again by intoxication, called for instrumental evacuation of the bladder. Falling, after repeated efforts with the usual gum elastic and rigid catheters, recourse was had to Dr. SQUIRE's vertebrated prostatic catheter, which entered the bladder with perfect ease, and three pints of urine flowed away.

Dr. Squire read the history of a case of prostatic enlargement in a patient 73 years old, in whom a moderate amount of such disease had existed thirty years. An accumulation of urine in the bladder made it necessary to introduce the catheter. Repeated attempts were instituted by careful and intelligent physicians, but the bladder was not entered. At this juncture Dr. Squire was called in consultation. The patient was in a sinking condition, and though gentle but persistent efforts to pass instruments of various curves and sizes were made, including Dr. Squire's vertebrated catheter, an impassable barrier at the neck of the bladder existed, and that viscus was not reached. Death ensued in a few days, and a careful *post-mortem* examination revealed extensive condensation of the coats of the bladder, with an abscess in their walls and such a thickened and enlarged state of the prostate gland as caused the direction of the urethra to assume the form of a right angle, at which point the instruments were arrested in their course. The morbid specimen was shown, and its rare interest and peculiarity, as minutely and clearly described by Dr. Squire, rendered it the subject of more than common inspection and discussion. Nearly all the members took part in the remarks that followed the reading of the paper and the explanation of the specimen. In the same connection, and illustrating the case under consideration, Dr. Squire exhibited a diagram, in which a sectional view of the bladder and urethra

was given, with accurate measurements of distances and the relative situation of adjoining parts.

Dr. MEISEL exhibited a boy five years old, with necrosis of the radius and ulna of right side, in whom as many as twelve abscesses had formed in various parts of the body.

Dr. E. L. HART related the features of a case of parotitis in a boy twelve years old, in whom, after two days, the swelling of the gland abated and the brain and lungs became involved, producing delirium and great difficulty of breathing. These symptoms continued, with marked typhoid depression, for ten days, when, with a gradual improvement in the boy's condition, the parotid gland again began to swell. Convalescence was now fully established.

Dr. STANCHFIELD read a case of retention of urine in a man 57 years of age, in which, unable to pass a common silver catheter, Dr. Squire's vertebrated catheter readily and without pain entered the bladder, as if by its own gravity. Upon the evacuation of urine a tumor was discovered in the lower part of the abdomen, which increased rapidly in size, and soon presented evidences of suppuration. It was opened through the abdominal parietes and three pints of pus escaped. The man is doing well and will completely recover.

Dr. WEY read a case of backward dislocation of the os lunare, in a boy 13 years old, produced by being thrown or jerked violently against a stationary desk in school, and striking against the back of the hand, which was bent forcibly toward the palmar surface of the arm. Reduction was effected by extension of the hand and pressure upon the displaced bone. The great rarity of the case led to its being reported.

Dr. VELDER read the history of a case of dislocation of the first metatarso-cuneiform articulation, in a man set. 30 years, produced by great violence in bending the foot, which was successfully reduced by manipulation, under chloroform and ether. Perfect restoration of the usefulness of the foot has resulted. This dislocation is among the rarest in surgery.

Dr. Squire, essayist, read a paper with the title, "A few thoughts upon the subject of Fractures." Alluding to an address on fractures, delivered as retiring President two years before, he said, "I then emphatically stated that the first and most important indication in the treatment of fractures is to maintain the circulation of the injured limb in the most healthy condition possible." In enlarging upon this idea, he reported a case of fracture of the radius, with great injury to the integuments, caused by having the arm caught between car bumpers, in which suitable treatment preserved a very useful limb. A case of compound fracture of the humerus was particularly detailed. An instance of non-union of the femur was mentioned, and one of

fracture of the inner condyle, now under treatment, was commented upon. These cases were made to illustrate the principles upon which the paper treats fractures.

Dr. Wey, essayist, read a paper headed "Some considerations why the Commissioner of Pensions should be sustained by the United States Government and by the Medical Profession, for his recent

course in dismissing a homoeopathic practitioner from a local Board of Examining Surgeons for Pensions." This paper was based upon six specific reasons for justifying the action of the Commissioner of Pensions.

Upon the appointment of Drs. Chubbuck and Bailey as essayists for the next meeting, on the second Tuesday in June, the Society adjourned.

EDITORIAL DEPARTMENT.

PERISCOPE.

Color-Blindness and its Acquisition through the Abuse of Alcohol and Tobacco.

Dr. RICHARD H. DERBY, late Assistant-Surgeon of Prof. VON GRAEFE, at Berlin, says in the *N. Y. Med. Journal*:

Achromatopsia, akyanopsia (Graefe), anerythropia, or Daltonism, are but a few of the names that have at various times been applied to color-blindness.

In the text-books we find cases of this affection cited as literary curiosities. It was believed to be nearly always congenital, and not amenable to treatment.

Modern investigators have immensely enriched this previously barren field. Color-blindness has been found an almost constant accompaniment of certain diseases of the optic nerve and retina. Excessive use of alcohol and tobacco is now known to produce color-blindness over a portion or the entire extent of the visual field. Exposure to wet and cold may lead to the same condition.

In many cases of amblyopia, an examination of the perception of color reveals functional changes most marked, and indeed in many cases, where the ordinary tests would indicate no pronounced difference in the acuteness of vision in various portions of the visual field, we find a most clearly-defined central color scotoma.

The question may be asked, if color-blindness is so constant a symptom in certain forms of amblyopia, why is it that patients so rarely complain of it? The explanation is undoubtedly in the fact that "the simultaneous falling off of the acuteness of vision appears to them relatively a far more grievous affection, and a disturbance in their perception of color seems natural. They are apt too to compare their present amount of vision with what their normal vision was by poor light.

"With deficient illumination at a certain point we lose the power of recognizing, not only the outline, but the color of objects; we distinguish

only light from darkness. Consequently the attention of the patient is only drawn to his color-blindness in those cases where it is very pronounced, and where, on the other hand, the amblyopia is slight.

"The fact that color-blindness and amblyopia are not necessarily associated together is reason enough that the condition of the perception of color should be especially examined in affections of the eye; such an examination may reveal us facts striking and unexpected, of importance for our diagnosis and prognosis."

On Santonine, as a Cause of Urticaria

Dr. E. H. SIEVEKING, physician in ordinary to H. R. H. the Prince of Wales; physician to St. Mary's Hospital, etc., says in the *British Medical Journal*:

I recently prescribed for a little patient of four years old three grains of santonine with five of sugar, which were given to her with her tea; and the nurse was of opinion that she could not have taken the entire dose, as the cup was not emptied. Very soon afterward, vomiting, accompanied by a severe rash, described as urticaria, and covering the greater part of the body, set in. I saw her soon afterward, and found her somewhat prostrated by the attack, but otherwise presenting no unusual symptoms. As, on inquiry, it appeared that some error in diet had been committed, I was not disposed to attribute the effect to the santonine, and therefore ordered the dose to be repeated on the following day. Almost directly after taking the medicine (and this time, again, it is probable that only a portion was taken), a white wheal appeared on the nose, surrounded by an erythematous blush; and a similar eruption rapidly covered the body. Violent vomiting set in, but unaccompanied by abdominal or other pain, or by purging; and the entire face became swollen. This swelling attained such a height, that when I reached the house, within a quarter of an hour of the commencement of the symptoms, the child's face was disfigured to such an extent as to make her almost unrecognizable.

*Leberk; Archiv f. Ophth. xv., 3, p. 23.

ble. The lips, from which some viscid saliva was still issuing, were swollen to an enormous size, glistening from the cedematous distention. The nose—at other times a delicate feature in a sweet little face—was enlarged to the size of a negro's; and the eyes were almost closed by the same condition of the lids. The intellect was unimpaired; and there were no spasmodic or other symptoms referable to the cerebro-spinal centres. I at once placed the child in a warm bath, which soothed her; and within an hour the edema and the rash had for the most part disappeared. No further bad result followed; but, on the contrary, although no vermifuge effect was noticed, the child's appetite and general condition were improved on the following day, after a night of sound sleep.

It naturally suggested itself that the powder had not been properly made up; and that some ingredient, for or besides those ordered, might have been introduced. But an analysis, kindly made for me by Mr. Squire, satisfied me that there was no ground for this assumption, and that the result could be attributed solely to the santonine. The analogy presented by the symptoms occasionally resulting from the use of copaiba, the consumption of honey, of shrimps, of mussels, of strawberries, assist us but little in the explanation of the occurrence; but it seems clear that the effect resulted mainly from a peculiar irritation applied to the pneumogastric and sympathetic nerves. The vaso-motor nerves were evidently largely implicated; but I do not remember ever seeing an instance in which so large an effusion of serum took place with the same rapidity, or disappeared as quickly.

The Cure of Fistula in Ano Without the Knife.

Dr. EDWARD C. HUSE, of Rockford, Ill., writes to the *Medical Record*:

A prompt and successful result, in several cases of anal fistula treated by injection of iodine, has induced me to call attention to this subject. While disclaiming, of course, any originality for this *plan* of treatment, the *manner* in which I have employed it is probably somewhat new. At all events, it has thus far been entirely and permanently successful in my hands; and the suggestions of M. HENRY, assistant to M. BONNAFONT, as long ago as 1858, on this subject, seem to have met with undeserved neglect.

The iodine should be employed in the form of a saturated ethereal tincture. Its advantages over the official or alcoholic tincture are obvious. It is not only *stronger*, and thereby excites inflammatory adhesion in the walls of the tube, but the ether evaporates almost momentarily, and a pure coating of iodine is left along the fistulous track, which doubtless encourages absorption.

The instrument I have used is an ordinary hypodermic syringe, with small silver canula, which may be readily bent to correspond with the direction of the sinus.

The mode of operation is as follows: After exploring the fistula with a *very small* probe (the ordinary probe of the pocket-case is far too large), after determining its course and extent, the patient is to be placed in a good light and a glass rectal speculum introduced, with its fenestrum opposite the internal orifice of the fistula. The canula is now bent to the required curvature and introduced, when the syringe, filled with tepid water, is screwed on, and the surface thoroughly cleansed of all extraneous matter. This step is not only essential, but serves to allay timidity, or dread of the subsequent operation.

Next, by pressure, the fistula in its whole extent should be dried out, and the iodine will thus come in direct contact with its walls. Introduce now into the speculum a quantity of carded cotton. This will absorb any of the iodine which might otherwise be injected *through* and injure the mucous membrane, and by its characteristic stain will serve to show the completeness both of the fistula and of the operation.

The canula may now be re-inserted and the injection made. It should be done *slowly*, and at the same time the canula gradually withdrawn. Every part of the surface will thereby be reached.

The operation, which is not very painful, should be premised with a cathartic and followed with a full anodyne, as ordinarily with the time-honored knife method. The patient need not be confined to his bed, or room, even for an hour.

Causes of Failure in the Operation for Squint.

At a recent meeting of the Medical Society of London, Mr. SPENCER WATSON read a paper on the Causes of Failure in the Operation for Squint. He placed in the hands of the Fellows a copy of the results of an analysis of 103 cases of convergent strabismus. The causes of failure were enumerated under the following heads: 1. The pathological conditions were in some cases misapprehended. Squint had been supposed to depend in ordinary cases upon mechanical obstructions to the movement of the muscles, or to bands of fascia. But, from the free mobility of the squinting eye, when the other was closed, this was evidently an error. In two-thirds of the cases, hypermetropia was one of the conditions present in squint. At the same time, retinal changes had a material influence in determining the permanent character of the squint. 2. The operation might fail in improper cases: for instance, where there was eccentric fixation, an apparent strabismus was seen, and here an operation would give rise to diplopia, and would not probably

produce improvement in the patient's condition unless the other eye were much impaired in visual power. Or, again, strabismus might be apparent where one eye was very much larger than the other from progressive myopia in one, the other being normal. The cornea of the smaller eye appeared nearer the inner canthus than that of the larger eye, and this appearance might mislead the surgeon. 3. The operation might fail from not being properly performed; the tendon might be missed, or divided too far from the sclerotic insertion. 4. The after-treatment might be improper; the patient might object to a second operation, or to the wearing of spectacles; or, the refraction not having been ascertained, the surgeon might neglect to order the necessary glasses, or might cover up the eye too long. In certain cases of periodic squint, apparent squint, and squint in very young children who could not wear glasses, as well as in cases due to brain-disease, the operation should not be performed. Mr. Watson remarked on the importance of adapting the kind of operation to the size of the squint, and the advantage of using the strabismometer before operating. The strabismometer of the late Mr. Zachariah Laurence was the most convenient and effective.

Traumatic Aneurism.

Prof BRIGGS, of Nashville, in the *Nashville Journal of Medicine and Surgery*, gives the following cases of this disease:

My experience sustains the teachings of Guthrie, that there is no assurance against hemorrhage in traumatic aneurism, whether diffused or circumscribed, except by a ligature above and below the wound in the vessel. A case which came under my observation during last summer will serve as an illustration.

A young man let his knife, which he held open in his hand, fall, the point entering about two inches below Poupart's ligament, directly over the sartorius muscle, passing obliquely downward and inward to the extent of an inch or more. A gush of arterial blood escaped at the time, but hemorrhage was arrested by pressure, and the wound healed promptly. In a few days afterward an aneurismal tumor formed at the point of injury, as large as a goose egg, and perfectly circumscribed.

Four weeks after the injury, the skin over the tumor becoming very thin, I was summoned to operate. Making an incision over the tumor from the upper to the lower part, the femoral artery was exposed just as it entered the sac. I placed a ligature on it at that point. Every physician present was satisfied that there would be no hemorrhage when the sac was opened. To prove to them that there would be considerable hemorrhage from the

lower end of the artery, I placed a tourniquet on the limb below the wound, loosely, with directions to tighten the moment I made an incision into the sac. As soon as I did so a few clots were discharged and then a stream of blood was thrown three or four feet in height, which was promptly arrested by screwing up the tourniquet, when I proceeded to sponge out the sac and place a ligature on each side of the puncture in the vessel. The patient was well in a short time.

I will allude to another case which occurred in my practice several years since. A gentleman received a gunshot wound in the inner and upper part of the thigh, the ball ranging inward toward the femoral artery. In a few days a circumscribed aneurism formed just below Poupart's ligament. I ligated the external iliac artery. The tumor was very much diminished in size, and its pulsation almost checked. Four weeks afterward, the sac having inflamed and suppurated, it opened spontaneously, and such a discharge of blood followed as reduced the patient to an extreme condition before the nurse, who had been fully instructed, could arrest it by pressure. When a free incision had been made into the sac, the wound of the artery was found after a tedious search, and a ligature applied to the lower end of the artery. He recovered after an illness of two months or more.

To Have Good Water.

An article by Mr. M'GORDON, in the *Med. Times and Gazette* (London), says:

The only practical mode of pipe construction which appears to meet on the one hand the requirements of purity and wholesomeness, and on the other cheapness and ductility, is a block tin pipe, encased in lead, the two metals so formed in conjunction with each other as to combine the qualities of ductility and pliability of the lead with the innocuous character and superior tenacity of the tin. The lead casing, which forms a protective coating to the tin pipe, being largely in excess, imparts to the pipe in its combined form the physical qualities which characterize lead, and the two pipes being so united at their surfaces of contact as to be inseparable by any contortion to which they may be subjected. The method of producing this pipe is simple and inexpensive, and consists in forming an ingot of lead, enclosing an ingot of tin, and forcing them simultaneously through a die and over a cone by the usual hydraulic power. The superior tenacity and lower specific gravity of the tin admits of such a diminution in the thickness and weight of the pipe that the manufacturers are enabled to offer it at the same price per yard as lead pipe of equal strength. In other words, it will cost no more to fit up a dwelling with this pipe than with the ordinary lead pipe. From experiments which have been

made by the coöperations of Glasgow and in this town, it has been found that this pipe possesses a power of resistance to pressure even greater than that of lead pipe, more than double its weight per yard. Mr. McGordon stated, in conclusion, that wherever the invention had been applied, its sanitary value had been found perfect. The manufacture was daily increasing, and its merits were being recognized, not only in this country, but in foreign countries.

Is it Right to Vaccinate or Re-Vaccinate Pregnant Women.

ROBERT BARNES, M. D., obstetric physician, and lecturer on midwifery and diseases of women and children at St. Thomas's Hospital, writes to the *British Medical Journal* on this topic:

The question has frequently been put to me, Is it right to vaccinate pregnant women? Some persons seem to entertain the apprehension that pregnant women incur special and serious risks under vaccination. To justify exceptional neglect of vaccination in their case, it ought to be shown, not only what this special risk is, but also that it is more serious than the risk incurred by the women themselves by taking small-pox, and thus of propagating the disease to others. The community, as well as the pregnant women, must be consulted.

To make out, then, a case for special exemption, it ought to be shown that the pregnant woman incurs a particular danger. Where is the evidence of this? The following passage from Dr. MEIGS's work on *Diseases of Females* (1848) has been cited to me as authoritative in this matter. "Do not," says Dr. Meigs, "vaccinate women when pregnant. I have been the witness of dreadful distress from the operation. Eschew it, I entreat you." It would be very desirable to have the cases justifying this very emphatic assertion recorded. I fear there is some confusion in the matter. Then, asking for evidences of mischief, as of abortion, from vaccination, I have been told of abortion and serious illness following small-pox. I do not doubt that small-pox is a most serious accident to a pregnant woman. But does it not follow, *a fortiori*, that pregnant women should be protected against small-pox?

My own experience has supplied me with many illustrations, which warrant the following propositions:

1. Pregnant women living under epidemic or zymotic influences, are more prone to take the prevalent morbid poisons than others.
2. Having taken a morbid poison, they are less able to throw it off. Their excreting organs, charged with the double duty of purifying two organisms are liable to break down under the additional burden.

3. The morbid poison pursues its course in a system which is less able to resist its injurious action. Abortion, and a most dangerous form of puerperal fever, are very likely to follow.

Against this certainly greater risk of taking small-pox, and certainly greater severity of the disease, if taken, what, I ask again, is the special danger of vaccination or revaccination? The operation, we know, is not altogether free from danger in adults of either sex. Before resorting to it it is wise to get the system into good condition. Do pregnant women run more risk than other adults? Probably they are at some disadvantage. But I believe that the special dread of abortion is exaggerated, if not altogether unfounded. The healthy ovum clings to a healthy uterus with wonderful tenacity. An ordinary illness, much less the slight febrile disturbance of vaccination, will not affect this relation. On the other hand, slighter causes may precipitate an abortion already imminent.

So far is vaccination from causing abortion, that cases are known in which the fetus has gone safely through the vaccine disease *in utero*, so that it has subsequently been proof against vaccination.

I think, then, we may conclude, in the absence of decisive evidence of special danger, that pregnant women are entitled to equal protection against small-pox with the rest of the community; and that vaccination or revaccination should be practiced on pregnant women in their own interest, as well as that of the community of which they form a part.

The Use of Purgatives.

The *Medical Press and Circular* reports a lecture by Dr. CARR, in which he says:

A dietary capable of nourishing the body, and yet of favoring daily or bi-daily relief, is very desirable, and may be readily discovered. In the case of young children who live mainly on milk and farinaceous food, and who are torpid, the substitution of cream for milk is of great value; the omission of casein as a food, and the substitution of butter, proves a great boon. In children, who partake largely of animal food, the decrease of this, and the increase of vegetables, will effect the desired change; or fruits, baked apples, prunes, and the like, will be followed by good. The torpid state of young people, middle aged, and aged, will often be cured by eating brown instead of white bread, or drinking a tumbler of water early in the morning. Oatmeal porridge, with cream or treacle, has proved a great boon to many habitual torpids. Above all, habit does much; the forced visit paid immediately after breakfast will often induce, if persevered in, the daily relief; and, if repeated in the evening, will be followed by an equally satisfactory result.

Regular walking, in addition to change of diet, will also do much to effect a cure. Should, however, these fail, recourse must be had to drugs, and of these, usually, the mildest are the best. It is also worthy of remark, that all forms of aperients answer best, if taken at bedtime. Thus, among the laxatives, castor oil is the most reliable; and a teaspoonful taken at bedtime for a night or two will usually produce free defecation. Among the salines, sulphates of magnesia and potash are the best; and the former combined with taraxacum, the latter with rhubarb, form excellent cathartics. The most valuable of the acrid cathartics are senna and jalap, both of which require to be combined with carminatives. If hydrocatharsis is desired, bitartrate of potash should be given with jalap, or elaterium may be used. For removing evident hepatic affections, the various forms of mercury may be given, notwithstanding the opinions entertained by Dr. Hughes Bennett.

As a record of the value of purgatives in special cases, we possess no better book than that of Dr. Hamilton, who wrote in 1805. Dr. Carr's experience supports this writer, and he further remarks that habitually torpid bowels are always accompanied by more or less of disturbed health, an unhealthy skin, usually yellow, with fetid breath. Such being the case, it is the duty of the judicious medical man to ascertain the causes of this torpor, and, if possible, to remove it. If the diet or habits be faulty, to correct it; and, this failing, then to give suitable drugs. Against interference, it has been urged that many persons will pass days or weeks without relief, and yet retain health; to which it may be replied, that these cases are exceptions; that, as a rule, health is alone possessed by the individual who obeys the laws of nature, and defecates once a day. So important is this to the well being of the individual, whether young or old, that its omission is, as a rule, followed by functional disturbance, and, if continued, by actual disease. And this fact cannot be too much impressed on all persons. Hence, the management of the bowels in early life should be well understood by mothers; so, too, their proper regulation in the middle periods of life; and the care of these organs should be well regarded in the decline of life—not so much by physic as by the laws of common sense. Here the value of enemata may be spoken of—they simply empty an over-loaded rectum.

Of the evils of purgatives, Dr. Carr dwelt with much force, contrasting the practice of the present day, which goes in for gentle rather than strong remedies, with that of thirty years ago. No form of cathartic can do good over and above the removing from the *prima via* its contents, and the exciting the exhalents to pour out of the blood its serum. Purgation must be, after the removal of the excreta,

a weakening process, and should never be practiced in cases of atonic disease, or where there is a condition of shock. In the parturient state, it is always a good rule to pass three or four days without relief, after which, if there be no action, to give at bedtime a teaspoonful of castor oil.

Aperients should seldom be given in known or suspected malignant disease of the abdominal viscera. In these cases, opium combined with belladonna will give the needful relief. A similar treatment Dr. Carr always practices in cases of acute torpor with urgent symptoms of constipation, severe abdominal pain, and sickness with a high temperature; repeated doses of opium with belladonna, and continued for a few days, usually succeed in obtaining the desired alvine evacuation.

In persons whose powers are feeble, and who eat both little and light food, the daily relief may be, as pointed out by Sir HENRY HOLLAND, too much. An action on alternate days, in their peculiar circumstances, is far better; still with them it is very undesirable to permit the bowels to get overloaded.

It will thus be seen that, as a rule, health is maintained by obtaining a daily relief; that diet and good habits favor this; that, failing the good rule, gentle medicines will establish it; and that strong purgatives should be rarely resorted to.

How are Idiopathic Fevers Cured?

JEROME COCHRAN, M. D., of Mobile, Alabama, communicates the following article to the *Nashville Journal of Medicine and Surgery*:

There is no section of the science of Medicine of more interest than that which treats of the Idiopathic Fevers. The principal diseases which belong to this group are small-pox, measles, scarlatina, typhus fever, typhoid fever, yellow fever, and malarial fever. Erysipelas, varicella, whooping cough, and some others, may also, perhaps, be included in the same class. Each of these fevers is caused by the introduction into the system of a specific poison, which generates a specific disease, with a specific train of symptoms; and each of them runs through a definite course of pathological changes, which no skill of the physician, and no healing virtue of drugs, can arrest in any of its stages. For example, the natural period of typhoid fever is twenty-one days; and no case of it was ever known, under any treatment, to recover in less time. The natural period of small-pox is fourteen days; the natural period of measles is seven days; and the natural period of scarlet fever is five days. Various complications and *sequelæ* may keep the patient sick a little longer; but the specific fevers themselves run through their several stages in the times I have mentioned, and no agencies, the most potent, of medical science, will enable us to abridge their du-

ration. They all observe the same law. They are all self-limited diseases. Each one of them runs on, from stage to stage, until the susceptibility of the system to the poison which produces it is exhausted—until the action of the poison is no longer poisonous; and then, when the malignant energy of the poison can no longer find a vulnerable point in the system, the disease spontaneously subsides—dies, because it can no longer find food to keep it alive.

There are only three ways conceivable in which these fevers can be cured by medicine.

1st. The medicine may act on the poison which produces the fever, may neutralize the poison by some occult agency of physics or of chemistry, may so change its static condition, or its dynamic condition, as to make it innocuous to the human organism. This is a method of cure which may be speculatively entertained. As a provisional hypothesis, it is entirely legitimate. But when it is weighed in the balances of rational medicine, it is found wanting. Not one empirical fact, not one practical observation can be found, anywhere, to sustain it. These fever-poisons have never been isolated. Of their physical and chemical properties we know nothing. We do not even know whether they are separate material miasms, floating in air or pent in stone; or whether they are simple malignant energies, dependent on some abnormal polarity of some normal constituent of the organism. The doctrine, then, of specific antidotes—of medicines which cure idiopathic fevers by neutralizing the poisons which generate the fevers, cannot be sustained by any appeal to facts, by any legerdemain of Baconian philosophy, by any method of empirical induction. Even if we had a complete antidote for any of these fever-poisons, it would be of very little practical value as a therapeutic agent. For, as the poison passes continuously into the system from without, or is continuously generated in the system by some inexplicable morbid process, and so saturates the blood in its whole course through all the tissues and organs of the body, it is evident that the antidote, also, would have to be introduced into the system continuously, so that the blood might be saturated with that also; because, in no other way could its neutralizing power be efficiently exerted. The continuous malignant activity of the poison would need to be met by the continuous beneficent activity of the antidote, and this would require its continuous administration; and the practical result would be that the recovery of the patient would be indefinitely protracted. As long as the patient was exposed to the poison, with his system susceptible to its influence, he would need the protection of the antidote.

2d. The second way in which it is conceivable for medicines to cure idiopathic fevers, is for the medicine to act on the patient so as to cause the

elimination of the poison. But here, again, the continuous introduction of the poison would need to be met by its continuous elimination, and this would result in the continuous administration of the medicine, and the indefinite protraction of the disease. For, if the elimination ceased, while the poison still continued to pour into the organism, and while the organism was still susceptible to its influence, the accumulation would soon be sufficient to reestablish the disease.

3d. The third way in which it is conceivable for medicine to cure idiopathic fevers, is for the medicine to act on the patient so as to destroy the susceptibility of the system to the influence of the poison. This method of cure is not liable to the same rational objections that have been shown to invalidate the method of neutralization, which would destroy the poison in the system, and the method of elimination, which would forcibly expel the poison from the system. It is theoretically sound. It is proof against all rational criticism. The difficulties it has to contend against are all practical difficulties, growing out of the limitations of our *materia medica*. In a word, we have not got the remedies to meet the indication. Leaving malarial fever and its remedies, for the present, out of view, we know of no medicines by which the susceptibility of the system to the etiological poisons of the idiopathic fevers can be destroyed. What then? If, of the only three imaginable methods of cure, two are theoretically impossible, and the third is impracticable because of the limitation of our therapeutic resources, it follows, of necessity, that in the present state of knowledge, idiopathic fevers cannot be cured by the use of medicines. Whatever means of investigation we make use of, to this conclusion we must come at last. So far as medicines are concerned, the idiopathic fevers are incurable diseases, malarial fever always excepted. No man can cure typhoid, or typhus, small-pox, measles, or scarlet fever. They are self-limited diseases, and get well of themselves, when they get well at all—subside spontaneously, when they have run through all their regular pathological changes—when, in a word, the system is no longer susceptible to the morbid influence of the poisons which produce them. For, happily, that insusceptibility which medicines are not able to establish, that blessed immunity which human science is not able to confer, is wrought out for the patient by the disease which ravages his system. What this wonderful change is, we cannot even guess. Whether some element of the blood, which serves as a pabulum for the poison, is destroyed; or whether some new element is introduced into the blood which has the power to withstand the poison; or whether there is some alteration of nervous polarity which protects the organic nervous system against the assaults

of the poison, we cannot tell. But we know that some change is wrought in the organism, which makes it no longer susceptible to the poisonous influence. We know that in most cases, and in most of these fevers, the immunity thus obtained is permanent, lasting for the rest of the patient's life. We know, also, that the recovery of fever patients is due to the spontaneous subsidence of the fever, which subsidence is due to the destruction of the susceptibility of the patient's system to the influence of the fever poison; and we know that fever patients never get well in any other way but this, keeping in view the seemingly exceptional case of malarial fever, because I do not believe that it is really an exception, but that it also conforms to the general law. I do not believe in exceptions to natural laws. Nature works in no such bungling fashion, and tolerates no such impertinent monstrosities. There is no more stupid maxim than "*Excerptis perobuat regulam*," in the sense in which it is usually employed, although there is a sense in which it is true enough—the sense, namely, in which the existence of the exception, as a fact, proves the existence of the rule, as a fact; but without proving the truth of either. The difference, on this point, between malarial fever and the other idiopathic fevers, is found in the fact that, while the exhaustion of the susceptibility of the system to the influence of the specific poisons which generate them, is, in all the others, usually permanent, in malarial fever the exhaustion of susceptibility is usually, perhaps always, temporary—lasting, indeed, but a few hours in a great many cases.

This hypothesis furnishes the readiest explanation of that *rezata questio* of speculative pathology, the intermittance of malarial fevers. Take the tertian intermittent as the most perfect form of the disease. The patient goes to bed at night well; he gets up in the morning feeling a little languid and feeble; about nine or ten o'clock he has a chill; in twenty or thirty minutes this is followed by a fever; the fever lasts four, five, or six hours, and passes off with a sweat; and then the patient feels well again; eats and sleeps, and goes about his usual work. He feels well, because he is well; the disease, *pro tempore*, has been conquered; he remains well during the whole of the next day; but, on the third day, the disease returns at the same hour, and passes through the same stages as before. Now what is the meaning of these phenomena? Simply this: The paroxysm comes on in the morning, because, perhaps, the poison exists near the surface of the earth in greater concentration during the night than during the day, and enters the system more rapidly; and partly, also, because while the nervous energy is benumbed by sleep, it is less able to resist the morbid influence of the poison. Thus the conservative energies of the

system are overpowered. Then follows the shuddering horror of the chill, the period of trepidation, the period of fright. But this does not last long; all the organic powers are summoned to the rescue. Then comes the dreadful struggle, the fight, the period of febrile reaction; the invading poison is forced to retreat, and the controlling influence of the organic nervous energy is reestablished throughout the system. For the time, the patient is well. He takes great draughts of malaria with impunity. He plays the role of Mithridates. But in forty-eight hours his susceptibility returns, and he has another paroxysm like the first. And these tertian paroxysms continue indefinitely; the patient is one day sick and one day well, until, perhaps, the disease lapses into a remittant, or until the patient is removed to a more salubrious locality, where there is no malaria among the things that flesh is heir to; or until the cold weather comes, and destroys the malaria; or until the physician interposes the protective influence of the quinine, the most beneficent of therapeutic agents.

The quinine acts, not by neutralizing the malaria in the system; and not by expelling the malaria from the system; but by fortifying the system against the influence of the malaria, by reinforcing the organic nervous energy so as to make it powerful enough victoriously to resist the malaria. While the organism, without extraneous aid, is usually unable to maintain its immunity from the influence of the poison but two days, the immunity following the administration of quinine usually lasts two weeks. In all forms of malarial fever, quinine is a specific remedy; not specific in the sense of a chemical antidote, changing the state of the malarial poison, either by decomposing it, in a manner analogous to that in which chlorine destroys the noxious effluvia of decaying vegetable or animal substances; or by forming, with it, new and more complex compounds, which, for some reason, are innocuous to the system—not a specific in this chemical sense, but a true therapeutic specific—a remedy which has the power to repair the ravages which the malaria has wrought in the organism—which increases the power of resistance against the morbid influence with which nature has endowed the organism—a remedy, in a word, which acts, not directly upon the poison producing the disease, but upon the organism itself.

Report of Five Cases of Typhus Fever Treated with Belladonna.

Dr. T. S. LATIMER says in the *Baltimore Medical Journal* for August:

A few months ago my attention was arrested by an article in the "*London Medical Times and Gazette*" on the use of belladonna in typhus fever. So signal was the benefit ascribed to it by the

writer, that I determined to try it at the first opportunity, for which I had not long to wait.

On the 29th of April I was called to see a negro girl, about 25 years old, living in an alley immediately in the rear of the jail, where, at that time, there were quite a number of cases of typhus. Though I could trace no direct communication with any one who had had the disease, the proximity of the jail and the filthiness of the neighborhood sufficiently accounted for its origin. I have had considerable familiarity with this disease in hospital practice, and had no difficulty in diagnosing the case before me. I shall not attempt to describe the symptoms at length; they were such as ordinarily characterize the disease, presenting no especial peculiarity. A few days of languor and lassitude, with dull headache, associated with constipation, preceded a slight chill, with subsequent fever, increase of headache, intellectual dullness, with a restless sense of danger giving to the face that peculiarly anxious expression quite characteristic of the disease, which gradually gave place to an expression of weary indifference, were the prominent symptoms in each of these cases. This girl had been confined to her bed two days when I saw her. She was in a filthy condition, as was everything else in the room. I ordered all her clothing to be changed, her whole body to be well washed, a mattress to be placed on the floor, on which she was put, and all other articles of bedding and wearing apparel to be removed from the room; that the whole house should be thrown open as freely as the weather would permit, and that every person living in the house should take a morning and evening bath. I then directed $\frac{1}{2}$ gr. of the extract of belladonna every four hours, the free use of beef tea, and that the whole surface of the body should be sponged with tepid water twice a day. This treatment was continued without modification of any kind until the 5th day of May, when I directed, in addition, one-half ounce of brandy every four hours. The patient did not become delirious until the seventh day, and the delirium began to subside about the tenth day; at no time was it very great. It was possible at all times to fix her attention and obtain intelligent answers to plain questions. By the twelfth day I believed her out of danger, and declared her convalescent. On the tenth day of her illness, the eighth of its administration, the belladonna was directed to be given but twice a day, and on the twelfth day it was stopped altogether, as was also the alcoholic stimulant, except that the yolk of an egg was occasionally given, beaten up with a tablespoonful of brandy, which proved a palatable, nutritious, and readily-digested article of diet. A rapid convalescence ensued, without the occurrence of retarding circumstances.

On the 12th of May a little daughter of the first patient, about six years of age, became affected in the same manner, and was put on the same treatment, the dose of belladonna being, of course, much diminished (1-40 gr. every four hours.) The strength began to fail a little earlier than in the former case, and it was necessary to use the alcoholic stimulant more freely. In no other respect did this case differ markedly from the first. Convalescence began about the same period, and progressed favorably to recovery.

On the 18th of May a negro woman, who had nursed the first case, was attacked, and the disease pursued the same course with little or no variation, except that there was a little more prostration, and convalescence did not begin quite so soon, nor progress so rapidly as in the other cases, owing, I have no doubt, to the fact that she was a delicate phthisical woman. The treatment was the same, except that in addition to the stimulant, which was used in the same quantity and with the same frequency, the yolk of an egg beaten up with brandy was taken twice a day. She seemed to enjoy the egg, and no unpleasant effect was observed from it.

On the same day (May 18th) I was called to see a white woman, *æt.* 38, who had had a slight chill on the previous day, was now suffering with violent headache and pain in the back, and indeed with very much the same train of symptoms as the cases just related; but I did not suspect the true nature of the disease, owing to the fact that she had had a large abscess in the submaxillary region, which had opened into the mouth a few days before. She having accidentally swallowed a part of the pus, was intensely nauseated, and vomited freely. I was therefore disposed to refer the condition of this patient to pyemia, thinking that a portion of the pus had been absorbed from the stomach, or perhaps from the seat of the abscess. Nor did I suspect the true nature of the disease until the seventh day, when her mother called my attention to an abundant eruption upon her body, which I at once recognized as the characteristic eruption of typhus. Up to this time I had been treating her with quinine and iron, with alcoholic stimulants, to which I now made the addition of the extract of belladonna, given with the same frequency and in the same quantity as in the other cases. The egg and brandy, and beef tea were freely given. This patient was confined to her bed about three weeks, and her convalescence has never been perfect. She is a phthisical subject, and that disease has made very rapid progress since the inception of typhus, and I think she has but a few months to live.

On the 2d of June a negro woman, who had been living in the same house with the first three patients during their entire illness, but had subsequently removed to another neighborhood, became

affected with the same disease, which pursued a course differing so little from those already related that no especial description is necessary. The belladonna was again administered, and the brandy for three or four days, during the most critical period of the disease, was given in tablespoonful doses, four times a day. She is now (June 27th) quite well, though of course she has not yet recovered her ordinary strength, and still has some stiffness and soreness about the joints.

In none of these cases could I observe any definite or special effect from the belladonna; but I am strongly inclined to believe it exerted a favorable influence on the general course of the disease, and somewhat lessened the severity and duration of the delirium. In neither case was any other medicine whatever used, except in that mistaken for pyemia, in which the quinine and iron were continued throughout the disease. The quantity of stimulus used was small, and that but for a short time, except where the phthisical complication existed. I am, however, disposed to refer considerable benefit to the frequent sponging, which certainly added greatly to the comfort of the patients and, I believe, to their recovery.

A Case of Hysteria in a Male Subject.

Dr. A. B. ARNOLD writes to the *Baltimore Medical Journal* for July, 1870: The following case derives its interest from the illustration it affords of the occurrence of hysterical symptoms in the male sex, and the influence which slight causes may exert in producing an apparent formidable neurosis.

A few days ago I was hastily summoned to see a man, who was pronounced to be in a dying condition. The patient appeared to be about twenty-five years of age, massive in structure, of elegant proportions, and of remarkable manly beauty. He laid on his back, stretched out in full, and continually either moaned, sobbed and flung about his arms, or was affected with stridulous breathing. When attempting to speak or swallow any fluid he was thrown into a fearful laryngismal spasm, with every sign of being in imminent danger of suffocation. These paroxysms were even excited by the least noise in the room. The man was perfectly rational, and immediately responded to the request of showing his tongue or changing the position of his body. By the movements of his hands he seemed to indicate that his greatest trouble was in his throat and chest. A physical examination elicited, however, nothing abnormal about these parts. From what I could learn from the people of the house it appeared that the young man was of sober, regular habits, and followed the profession of veterinary surgeon. He returned in the evening from a call in the country in a very prostrated condition, and

complained of having been suddenly taken ill with giddiness of the head, great oppression of breathing, wandering pains all over the body, and a sensation of faintness. On request to give some information of the previous state of his health, he wrote with a pencil on a slip of paper that he had suffered with gastric derangement for the last few days and occasional colic pains.

Sinapisms over the stomach had produced no relief, and it was out of the question to prescribe for him any internal remedies on account of his inability to swallow anything. Thinking that the inhalation of chloroform might do some good in removing the dysphagia and the evident spasmodic condition of the glottis and respiratory muscles, I began to administer this anæsthetic agent, but on taking the first whiff, the patient was immediately affected by one of the paroxysms, which induced me to desist. The great resemblance of some of the symptoms to hydrophobia caused me to make the proper inquiries, but I was assured that my conjectures were wrong. In course of about half an hour the labored and suffocative attacks were replaced by belching and retching, and the case took altogether a favorable turn.

I left the patient with the direction to soak a napkin with some brandy and water, for him to press out the liquid with his lips, and then to swallow it as best he could. On my next visit I found him perfectly restored, and walking about his room. He had followed my directions, and after repeated failures he succeeded in swallowing a large quantity of the stimulant, and soon after fell into a sound sleep.

Reduction of Hernia in the Erect Posture.

Dr. MCGEACHY in *The Canada Lancet* gives a case in which the patient was relieved by taxis in the erect posture, and adds the following remarks:

Firstly.—Obstinate constipation, or complete occlusion, may sometimes be caused by a partial incarceration of a portion of an intestine, which neither digital examination nor any physical means can properly demonstrate. The extreme importance of a proper diagnosis in suspected cases need not be insisted on. This patient had taken for two or three days previous enormous doses of salts, but without any effect; this I was not aware of at the time. I had a very interesting case of this kind some time ago, which terminated on the fourth day in complete relief, by spontaneous reduction.

Secondly.—Is the erect posture the proper one, or only accidentally advantageous? Might I presume to offer a theory to my medical brethren, which, in the absence of any other that I am aware of, may be thought worthy of some consideration?

I believe that the proper position, theoretically

for the reduction of a strangulated inguinal hernia, and in which alone the co-operation of dynamic agencies can be utilized, is the erect posture, with the flexure and adduction of the thigh.

The means to be used are obvious. If before, hand the colon be well evacuated, or as much so as possible, every rational preparatory condition will have been fulfilled. In the old position, but one force is brought to bear—the pushing force used by the operator, if I may so term it. By this method we have also a pulling force (viz. a fronte), namely, the weight of a large portion of the bowel striving to drag the remainder from its posture of imprisonment. Why not, then, invert the patient, and secure the action of this new force in a still greater degree? Simply this: The rhythmic action of the diaphragm forbids the continual operation of this force, and should it have any effect, it often leaves matters *in statu quo*, during its contraction. Besides the force here would generally be acting at an angle, the ring being the fixed point.

Thirdly.—Many practical men prefer this method of reduction, without regard to theory.

Pathology and Treatment of Tuberculosis.

WADE MINOR LOGAN, M. D., of Cincinnati, says, in the Cincinnati *Lancet and Observer* for August.

Without pausing to discuss the relative merits of the various theories that have been proposed concerning the nature of this disease, or for other preliminaries, I proceed to the consideration of some investigations that I have recently made.

The chemical analysis of tubercle shows that the phosphates, especially the phosphate of lime, is the inorganic element of this morbid deposit, just as iron is an inorganic element of hæmatin. And according to that law of physiological chemistry known as vital affinity, we would reasonably expect the introduction of the phosphates into the system of a tuberculous subject to give rise to a corresponding increase of the tubercular deposit. And by a series of experiments conducted by Mr. John Taylor upon tuberculous subjects in the Liverpool work-house, they were found to hasten the development of the disease; and would seem to tend conclusively, in the estimation of that gentleman, to the establishment of our hypothesis.

Such distinguished men as Profs. L. M. LAWSON, HENRY HARTSHORNE and GEO. B. WOOD, after repeated trial of the phosphates and hypophosphites of lime, soda, and potassa, have published the results of their experiments, expressing their discouragement.

I do not know of any who now claim for them that degree of reputation which Drs. STONE, CHURCHILL, and others, at one time anticipated that they would enjoy. I have, indeed, been em-

ployed in cases in which the patient had gradually sunk under them in the care of other and first-class practitioners, when a directly opposite course of medication was instituted, followed by the most flattering results.

"The urine of tuberculous subjects," says Lawson, "appears to contain less solid constituents, particularly the nitrogenized elements, while the salts, especially the phosphates, are in excess" (Lawson's Treatise, p. 464); and this statement has been supported by the majority of my own observation. NIEMEYER, in speaking of laryngeal phthisis, says, that in the progress of this disease, the laryngeal cartilages frequently undergo ossification. He also states, as do all others, that "it is exceptional for persons deformed by rachitis" (in whose systems there is a deficiency of the phosphates) "to become or die tuberculous." "Freund, of Breslau, regarded ossification of the first costal cartilage as a cause of phthisis, on the hypothesis that it prevented the free expansion of the chest, and by its acting as an irritant produced inflammation at the apices."

I myself, when a student, long before the conception of this theory, noticed in opening the chests of a number of tuberculous *cadavers*, that all the costal cartilages were quite hard; one case in particular, a young female, apparently about twenty years of age, in one of whose lungs were large tubercular masses, while in the other was a large cavity; and whose costal cartilages were almost as hard as bone, which I then attributed to the disturbance of circulation and nutrition as having probably given rise to an almost perfect state of dryness in those tissues. Dr. FRICK, of Baltimore, analyzed the blood of four cases during the existence of crude tubercles, and states that, among other deviations from the normal standard, he detected an increase of lime, the quantities in the different cases being respectively, .272, .257, .276, .283; remarkably contrasting with .183, the normal proportion; and BAUMES claims to have detected in the blood an excess of phosphoric acid. (Lawson's Treatise on Consumption, pp. 57 and 145.)

Again, bearing on this point, Dr. Lawson, in treating of gray tubercles, says, "they vary in size from that of a millet seed to that of a pea; and in consistence, from a soft structure to almost cartilaginous hardness, being somewhat friable, and presenting a granular surface when cut." (Lawson's Treatise, pp. 32 and 33.)

It is obvious that their soft structure is most probably due to the deposit being quite recent; still in a partial state of solution, their more fluid constituents not yet having been absorbed; and that "their almost cartilaginous hardness" is due to their being to a great extent of a calcareous nature, with their fluid properties completely absorbed.

In regard to cretaceous tubercle, Dr. Lawson

says, "the chemical analysis of cretaceous tubercle shows that the animal matter becomes absorbed, while the earthly or inorganic materials remain. The relative proportion of the organic and inorganic substances in the two forms of tubercle becomes exactly reversed when the cretaceous change occurs, which is doubtless due to the absorption of the organic, while the vessels are incapable of taking up the inorganic. Pathologists speak of this change as absorption of the organic elements, while the deposition of the inorganic continues, and thus replaces the former substance. According to this view, the earthly material is an independent secretion, continuing after the deposit of the ordinary tubercular matter has ceased. It is far more probable, however, that the whole mass is deposited in the usual form and composition of tubercle, and that the ulterior changes result from the absorption of the fluid elements, while the earthly substance, being incapable of reëntering the vessels, remains in the cavity." (Lawson's Treatise, p. 96.)

Thus it is seen that the phosphates, especially the phosphate of lime, perform no insignificant part in the process of tuberculization and development of phthisis.

Now, in regard to the origin of tuberculosis, let us draw a parallel, by which may be seen the most striking analogy. Sugar normally exists in the blood nowhere else than in venous circulation between the liver and lungs. In the lungs it is destroyed by the catalytic action of the air; being converted, first, into water; second, into lactic acid; third, into carbonic acid; then and there being voided by the respiratory process. (Williams' Principles of Medicine, p. 163.)

Now, if from some defect in elaboration (as often occurs in persons possessing the rheumatic diathesis), the third change, by which the lactic acid should be converted into carbonic acid, does not take place, blood poisoning would soon be manifested by symptoms of acute articular rheumatism.

So may it also seem probable that the phosphates, to a certain extent, normally undergo some catalytic or other change, either preparatory to performing or after having performed their function in the economy, and that in the presence of the tuberculous diathesis, by this physiological process being interfered with, either by preëxisting debilitating causes or otherwise, a state of cachexia or blood-poisoning is produced, which, failing to be eliminated from the system, increases in quantity until finally its existence becomes manifested by the familiar phenomena which accompany the development of tuberculosis.

Concerning the deposit of tubercles, the theory accepted by Lawson, Watson, and others, was, that it took place by the exudation (perhaps spontaneously in most cases) of a certain specific humor

(by us supposed to be to a great extent of a calcareous nature); and Prof. J. H. BENNETT says that "calcareous deposits which do not assume the form of a bony growth are usually the result of an exudation." (Bennett's Practice, 3d ed., p. 271.)

According to the accepted theory on tuberculosis proper, two separate and distinct forms of tubercle were recognized, viz.: the gray and the yellow. In regard to the ultimate tendency or result of the two varieties, Dr. Lawson says: "While the yellow variety naturally tends to softening and elimination, the gray as constantly undergoes a retrogressive action, and never softens except as a result of its possible transformation into the former species," etc. (Lawson's Treatise, p. 34.)

How could the gray become transformed into the yellow variety? By acting as a foreign body it would cause inflammation, and the consequent exudation would be in the immediate vicinity of and around the mechanical irritant, and as the more fluid constituents of the exudation would be becoming absorbed by the surrounding lung tissue, its more plastic or solid elements would accumulate around and adhere to the gray tubercle previously deposited, thus transforming the gray into the yellow variety. And we can thus easily understand why yellow tubercle contains a preponderance of albuminous or albuminoid material over either the gray or cretaceous varieties.

And the degraded condition of the blood plasma presently to be alluded to, which would furnish the exudation with corpuscular rather than coagulable lymph, explains in my opinion the source of the caseous matter of crude tubercles, which Niemeyer seems to have attributed to a different process. Then my opinion is, that after the tubercular exudation, or the exudation of the "*sui generis*" specific poison, that gray tubercle is the initial lesion of tuberculosis just as chancre is the initial lesion of syphilis.

(To be continued.)

Reviews and Book Notices.

NOTES ON BOOKS.

"Woman as a Physician," by Dr. J. P. CHESNEY, New Market, Mo., is a succinct and timely defense of the propriety of women practicing medicine if they see fit. Whether practically they ever will, in any important numbers, thus make a living we doubt, but certainly Dr. Chesney shows there is nothing improper in their attempting to do so.

Among recent foreign medical publications we note the following: JOS. BAWN, History of Venesection (*Geschichte der Aderlässe*), a prize essay, published in Munich.

April 8, 1871.]

Editorial.

303

MEDICAL AND SURGICAL REPORTER.

PHILADELPHIA, APRIL 8, 1871.

S. W. BUTLER, M. D., D. G. BRINTON, M. D., Editors.

Medical Society and Clinical Reports, Notes and Observations, Foreign and Domestic Correspondence, News, etc., of general medical interest, are respectfully solicited.

Articles of special importance, such especially as require original experimental research, analysis, or observation, will be liberally paid for.

To insure publication, articles must be *practical*, *brief* as possible to do justice to the subject, and *carefully* prepared, so as to require little revision.

We particularly value the practical experience of country practitioners, many of whom possess a fund of information that rightfully belongs to the profession.

The Proprietor and Editors disclaim all responsibility for statements made over the names of correspondents.

•INEBRIETY vs. INSANITY.

The "Tenth Annual Report of the Alabama Insane Hospital" by P. BRYCE, M. D., the Superintendent, discusses the subject of the treatment of inebriates, and the important question is asked, "are inebriates insane?" Distinguished authorities are quoted to prove the affirmative of this inquiry, and according to the author of this report, all these authorities concur in the opinion that inebriety is insanity, and taking their standard as the basis, Dr. Bryce proceeds to argue in favor of a "Reformatory for Inebriates" to be under the "jurisdiction of the courts." The scheme contemplates bringing the "facts before the grand jury, and upon the finding of a true bill, the case should be duly investigated by a jury," etc. The "allegations being proved," the inebriate should be committed for a term of not less than two, nor more than five years to the reformatory, and supported there at the expense of the State." The treatment recommended is compulsory labor. "Voluntary inebriates" should be received on "certificate of a Justice of the Peace that the applicant is a volunteer, and that the term of treatment has been determined by two intelligent physicians." These are the chief points to be observed in the "outline of a reformatory for inebriates." Dr. Bryce then asserts that "Inebriate Asylums upon the voluntary system alone, when the time of treatment is restricted to one year, however grand, imposing and complete their appointments, must necessarily, from the very nature of the disease which they profess to treat, prove failures in the end." Let us inquire:

If inebriates are insane, why not treat them in insane asylums? Why treat monomania as a disease with reference to its cure, and methomania as a crime to be reformed? Why admit the former to an asylum without indictment by Grand Jury, and compel the inebriate to submit to arraignment and trial before the same tribunal with thieves and murderers? Why compel "voluntary inebriates" to procure a certificate by a Justice as evidence that they are volunteers? Why leave the question of the length of residence of such volunteers in Reformatory to "two intelligent physicians," who do not propose to conduct the treatment, instead of to the Medical Superintendent of the institution receiving the inebriate?

But now for the results of institutions which are conducted on the voluntary system. We quote from the proceedings of the American Association for the cure of inebriates:

Washingtonian Home, Boston.—"More than thirteen years of experience, and the treatment of nearly three thousand five hundred patients have clearly demonstrated that under favorable circumstances even the worst cases of intemperance can be cured." * * "As soon as physical health is sufficiently restored, we allow to every one all the freedom he can reasonably look for in any well regulated family. Each one can come and go at his own option, and dispose of his time, while in the institution, to suit his own taste. We put every man upon his honor, and we find by long experience that such a guarantee insures a better discipline, a more correct behavior than any code of laws, or long list of imposing regulations can possibly enforce." —W. C. Laurence, Superintendent.

The Washingtonian Home is in the City of Boston, the average length of term does not reach three months, and the percentage of cures is larger than in insane asylums.

Inebriates Home, of Kings County, New York.—"Imprisonment for drunkenness is an outrage on civilization." * * "The home is conducted without written rules, and though the class of persons received there are, many of them, taken from prisons and police stations, and some of them belong to what is known as the dangerous classes, there is no difficulty in controlling them without bars or locks." * * "Fully one-third of the cases treated recover," and the average continu-

ance less than six months.—Rev. J. Willet, Superintendent.

Washingtonian Home, Chicago.—"If our asylums are made to partake much of the nature of the family, they will be more powerful for good." * * "But as a moral and social element of reform, cleanliness, punctuality and gentility, are very potent."—Dr. P. J. Wardner, Superintendent.

Pennsylvania Sanitarium, Media, Pa.—"Imposing public edifices, with surrounding walls, and guarded gates, for the purpose of separating their inmates from the heart of the community, may be well enough for convicts or maniacs, but for men of feeble will, or perverted tastes, or depraved appetites, or exhausted energies, or depressed spirits, such imposing structures are needless." * * "Their separation should be as little like separation as circumstances will permit, and therefore the buildings which they are to occupy should be as much like their homes, or homes which men are ambitious to possess and enjoy, as possible."—Joseph Parrish, M. D., Physician.

The Sanitarium is at Media, near Philadelphia, and about forty per cent. of cases recover. The average length of residence is one hundred days.

Other authorities might be cited to prove the value and success of institutes on the voluntary principle. The experience of insane asylums in the treatment of inebriates is not encouraging, as but few of them recover, and the reason probably is, that they are subjected to unsuitable restraints and surroundings. The testimony of the American Association for the cure of inebriates is conclusive and authoritative, and should be so accepted.

NEWS AND MISCELLANY.

The "Double Amputation" Case Again.

We have been requested to publish the following statements and certificates in the "Double Amputation" case. With this publication we cease all reference to the case. Our columns have been opened to both parties, and our readers must form their own opinions after having read both sides of the story.

Certificates.

MAHANAY CITY, Nov. 21, 1870.

This certifies that I was present at the operation on Mr. Ryce Griffith's limbs on the 22d of November, 1869. Dr. SWAYZE conducted the entire operation. I was chosen by Dr. Swayze to attend to the ether.

During the remainder of the operation, to the best of my knowledge, Idris Davies was a spectator, except that he occasionally felt the patient's pulse.

EDW. LATHAM.

MAHANAY CITY, PA., Dec. 23, 1870.

This is to certify that IDRIS DAVIES told me soon after the double amputation, in the case of Ryce Griffith, that Dr. SWAYZE performed the operation, and also that Dr. Swayze was a fine and cool operator.

JOHN F. HEMPELTY.

Statement of Physicians.

[Being, with one exception, members of the Schuylkill County Medical Society.]

MAHANAY CITY, PA., Dec. 30, 1870.

We, the undersigned physicians of Mahanoy City and vicinity, being acquainted with both Dr. Geo. B. H. Swayze and Idris Davies, unqualifiedly condemn the recent act of Idris Davies in attempting to defraud Dr. Swayze of the credit of the successful double amputation performed by said Dr. Swayze in the case of Ryce Griffith on the 22d of November, 1869.

We further state that we consider said Idris Davies an irregular practitioner, and have no professional intercourse with him whatever.

L. M. THOMPSON, M. D.
GEO. F. BRENDLE, M. D.
G. L. REAGAN, M. D.
P. HARMANY, M. D.
G. M. MILLER, M. D.
P. H. SHULTZ, M. D.
E. K. WEBER, M. D.
PHILIP WEBER, M. D.

Delegates.

At the late meeting of the Virginia Medical Society, Drs. BROWN, of Abingdon, and HORNER, of Fauquier county, were appointed delegates to the next meeting of the American Medical Association.

Medical Society of East Tennessee.

This Association was revived at a meeting held at Knoxville, February 2, 1871.

President—Dr. F. K. Bailey.

Vice Presidents—Drs. Jas. Rodgers and I. M. Boyd.

Recording Secretary—Dr. R. M. Rhea.

Corresponding Secretary—Dr. S. D. Moses.

Treasurer—Dr. S. M. Burnett.

—Two or three drops of the Prussian tincture on a lump of sugar, given three times a day, will usually relieve constipation.

KIV.

best
r, ex-
s.

70.
soon
Byce
ation,
oper-
LY.

of the

870.
y Clay
r. Geo.
ly con-
mpting
succes-
d Dr.
22d of

ris Da-
profes-

D.
D.

ical So-
INNER, of
es to the
ociation.

ing held

d L. M.

oses.

tinctive
day, will

MEDICAL AND SURGICAL REPORTER.

ORIGINAL

